WOODROW WILSON REHABILITATION CENTER
Fishersville, Virginia 22939-1500

MENTAL HEALTH ASSESSMENT CONSENT FOR MINORS

Client Name: _____ WWRC#: _____

I hereby consent and give permission to WWRC, its clinical psychologists, professional counselors, and mental health staff to interview and administer mental health procedures, and/or recommend treatments to my child/ward who is under legal age and is currently enrolled in a rehabilitation program at WWRC.

Mental health procedures include review of case records, clinical interview, and/or administration of educational, intelligence, or other psychological tests. The results are used to provide information to the client, professional staff, and family and to develop a written report specifying a treatment plan to help the individual improve skills in independent functioning.

_____I DO CONSENT to permit my child/ward to receive a mental health assessment.

_____I DO NOT consent to permit my child/ward to receive a mental health assessment.

I understand that prior to the administration of any test, procedure, or interview my ward will be informed of the risks and benefits, and that any questions he/she might have will be answered.

I understand that I have a right to refuse or withdraw consent. I can discuss the implications with the psychologist or mental health professionals at any time. Refusal or withdrawal of consent may impact the ability of WWRC to continue to provide rehabilitation services.

SIGNATURE OF PARENT or GUARDIAN:

X_____ Date: _____
PRINT NAME HERE: _____

Address: _____
Telephone: Work _____ Home _____

WITNESS: _____ Date: _____

PSY-2916
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